



Department of Labor and Industries  
Claims Section  
PO Box 44291  
Olympia WA 98504-4291



# REQUEST FOR CLAIM INFORMATION

(to be completed by worker, worker's representative  
employer, or employer's representative)



Department of Labor and Industries  
Self-Insurance  
PO Box 44892  
Olympia WA 98504-4892

*This form must be completed in full*

Claim No.

Worker's name

Name of person making request



Worker



Other

Date

Phone number

Address

City

State

ZIP + 4

## Copies of documents are a chargeable item

Please check the proper box(s).



I am requesting my claim file.



I am requesting the following information from my claim file:  
(for example, "the panel exam of Feb 4, 1977," etc.) Please list below.



I am the worker's authorized representative requesting the claim file for the worker named above.  
I understand that the file contains confidential information and by accepting the file, I accept full  
responsibility for any use made of this information. AUTHORIZATION IS:



ON FILE



ATTACHED



I am the employer or employer's representative requesting the claim file for the worker named above. I  
understand that the file contains confidential information and by accepting the file, I accept full  
responsibility for any use made of this information.

Signature

## For Department use only:

Action taken on request

Date action taken

Name of person taking the action

Section/office